



# State Supplementary Assistance Certification or Termination

From:
To:

The Department of Human Services has taken action to certify or to terminate optional State Supplementary Assistance benefits for this client. Please complete page 2 of this form and return it to the sending office.

### 1. CLIENT IDENTIFICATION

Name	SSN	Case Number
Address		Phone
Current SSI Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled		
Representative Name	<input type="checkbox"/> Conservator	<input type="checkbox"/> Payee <input type="checkbox"/> Guardian
Address		Phone
Contact Person Name	Relationship	
Address		Phone

### 2. CERTIFICATION

<input type="checkbox"/> Dependent Person <input type="checkbox"/> Family-Life Home	Effective Date	
Dependent Name	Age	Relationship
Family-Life Home Name		

### 3. TERMINATION

Date:	Cause: <input type="checkbox"/> Death <input type="checkbox"/> Removal of Dependent <input type="checkbox"/> Client Left
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### 4. COMMENTS

IM Signature	Date
Service Signature	Date

To be completed by the Social Security Administration

Return to Imaging Center:

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1. CLIENT INCOME INFORMATION

SSN:  
Case #:

Source	Amount
Total Gross Monthly Income	

2. SSI ELIGIBILITY DECISION

<input type="checkbox"/> Approved effective _____.
<input type="checkbox"/> Not applicable. Client is already receiving SSI.
<input type="checkbox"/> Denied because:

3. STATE SUPPLEMENTARY PAYMENT DECISION

<input type="checkbox"/> Approved for payment effective _____.
<input type="checkbox"/> Denied because:

4. TERMINATION

State supplement payment has been terminated effective _____.
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SSA Signature	Office	Date
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